Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 18, 2016

Ms. Debra Clemmer, Manager
Lakeview Community Care Home
322 St Paul Street
Burlington, VT 05401-4647

Dear Ms. Clemmer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 13, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

FEB 12 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite survey was completed on 1/13/16 by the Vermont Division of Licensing and Protection. The survey included review of a mandated facility self-report. The were no citations related to the self-report. The following regulatory violations resulted from the relicensure survey.	R100	Please see attached.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that each resident's care plan addressed all of the resident's assessed and identified needs for 2 of 5 residents in the sample. (Residents #2 and #4). Findings include: 1. Per record review and confirmed by staff interview (1/13/16), Resident #4 was frequently resistant to taking showers to maintain acceptable levels of his/her personal hygiene. The resident's showers were monitored by staff and reminders were given when the resident failed to complete the showers as scheduled weekly. The care plan failed identify this need and to include these interventions to assure acceptable personal hygiene was maintained. 2. Per record review. Resident #4 had sustained	R145		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Debra Clemmer RN / Program Coordinator 2/8/16

R145 - R302 POC's accepted 2/17/16 MBoltonRN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 1 a loss of more than 40 pounds since admission to the home in 2010. Although the resident has a history of compulsive behaviors (addressed under a plan for behaviors), there was no identification of a plan to address gradual weight loss as a goal due to decreased compulsive eating. The care plan omissions were confirmed during interview with the Administrator on the afternoon of 1/13/16.	R145		
R179 SS=A	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.	R179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to assure that all direct care staff completed the seven required annual in-services, as part of the total of 12 hours of annual in-services training required. (1 of 5 staff reviewed did not complete all trainings). Findings include: Per review of the documented staff trainings for the last 12 months on 1/12/16, 1 of the 5 staff reviewed for required trainings failed to complete the training related to Emergency Response and 1st Aid. This finding was confirmed during interview with the Administrator on the afternoon of 1/12/16.	R179		
R266 SS=B	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to assure that all areas of the home were maintained to assure a clean, sanitary and homelike environment. Findings include: Per observations during a tour of the home on 1/12/16 at 9:15 AM, the following areas were observed to be soiled and not maintained to be	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATIDN NUMBER:	(X2) MULTIPLE CONSTRUCTIDN	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATDRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CDRRECTION (EACH CDRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 3 homelike: 1st floor - The beige colored flooring in the hallways, living room, dining room and bathroom were all visibly soiled with a build up of black where the heavy foot traffic was and around the perimeters of all areas. The bathroom floor was very heavily soiled with black areas over most of the floor, the surface looked worn. The stairway to the second floor had visible heavy soiling and dust on the treads. 2nd floor - The hallway floor was soiled with a build up around the edges near the wall bases. The area just outside of the 2nd floor bathroom was heavily soiled with a black substance and there was a smell of urine in the hallway. Per interview with the Administrator after the tour on 1/12/16, s/he stated that the flooring was not very old but had not held up to the wear and tear of the household.	R266		
R302 SS=D	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be	R302		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0177	A. BUILDING: _____ B. WING _____	C 01/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW COMMUNITY CARE HOME	322 ST PAUL STREET BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R302	Continued From page 4 documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to assure that fire drills were conducted for 1 of the 4 required times of the day during the last 12 month period. Findings include: Per review of the schedule of fire drills conducted during the past 12 month period, there was no fire drill completed during the night time hours (between 12 midnight and 6:00 AM). Additionally, staff present for each drill documented their initials only, rather than including each staff member's full name, per requirements. The omissions were confirmed with the Administrator during interview on the afternoon of 1/12/16.	R302		

FEB 12 2016

Date: February 5, 2016

To: Pamela Cota

From: Debra Clemmer - Program Coordinator for Lakeview Community Care Home

Re: PLAN OF ACTION FROM THE JANUARY 13. 2016 SURVEY REVIEW

Deficiency R145: Resident #4 personal hygiene was not addressed enough in the care plan and also in this same resident her gradual weight loss was not addressed in the plan

Action: Resident #4 care plan was reviewed and the above deficiencies were addressed and added to the care plan.

Deficiency R179: One staff out of 5 reviewed did not receive yearly training related to Emergency Response and First Aid

Action: I checked records of all staff and they were up-to-date and had done the Emergency Response training. One staff missed the First Aid training. She is scheduled to take the class in the next month.

Deficiency R266: Soiled and worn floors in the common areas and bathrooms

Action: Lakeview cleaner is paying more attention to cleaning the floors especially scrubbing the build-up around the edges near the wall bases. She is moving furniture to clean under these areas. Ed Vizvarie Director of Facilities is having a floor specialist come in to get new flooring in all common areas, hall ways, and bathrooms and maybe bedrooms.

Deficiency R302: In the past 1 year there was not fire drill conducted between the hours of 12 am to 6 am. There is documentation of monthly fire drills

Action: Lakeview will conduct a fire drill between the hours of 12 am to 6 am within the next 2 months.